I believe that when you act from a sense of abundance, when you share the cookies your mom gave you, you receive abundance in return. I also believe that Endodontics, as a specialty, largely owes its dramatic growth to its history of sharing knowledge with generalists. My best evidence to back that statement is that despite decades of “show and tell” by my most esteemed endodontic colleagues, the number of endodontists continues to grow at a rapid rate. All of the established, progressive endodontic offices I know of are flush with referrals. Many of them are looking for associates or partners to help handle the load. Not a bad stunt, considering that we did our best to buy our own rope.

I recently witnessed an excellent example of endodontists sharing knowledge at the ADA meeting in Chicago. Joe Maggio, past president of the AAE, set up a panel discussion called “Endodontics A to Z, Ask Me.” Joe was the moderator of the panel that included Joe Grenn, an exceptional clinician and lecturer from San Francisco, Jerry Glickman, a very progressive educator and Chairman of Endodontics at the University of Texas at Houston, and myself.

It was extremely informative, it was to the point, and the attendees got to hear different views on several topics. The questions that were asked and answered were all clinically relevant and at no time was there a patronizing opinion from any of the panelists. We discussed the use and misuse of handpiece-driven nickel titanium files, diagnostic testing, emergency treatment, pain management strategies, and many other topics. When was the last time you saw a panel of oral surgeons, periodontists, or orthodontists put together to help general dentists treat patients in their area of expertise?

Another great example comes from a lab course I gave in Santa Barbara last week. When I start the workshop everyone introduces themselves and it turned out that two of the attendees were from the same town. The first of the two said he was a general dentist and that he was at the course because his local endodontist talked him into it. Wow! So the whole class is riveted to hear how the endodontist is going to explain his rationale for helping train his supposed competition.

The endodontist, Michael, made me proud to be a fellow specialist when he introduced himself and said that he had taken on the challenge of training up to the new endodontic technology about three years ago. He said that it had turbocharged his practice, as well as his enjoyment of practice. He invited his referring dentist because he also did endodontic treatment and Mike wanted him to be able to achieve the same quality of result. Mike got it exactly right.

Yet at times, there are difficulties between dentists treating patients together. I’ve seen that these situations nearly always occur because of misunderstandings and miscommunications, seldom due to poor intention on either party’s part. So, in the interests of helping us all play well together, allow me to offer a few ideas about how specialists and their referring dentists can achieve their full potential in this important relationship. Call it a “Miss Manners Gets a Root Canal” discussion, if you will.

Generalists:
Please don’t think that you are giving specialists a part of your practice when you refer, that we owe you more than our best service to your patient. At the end of an endodontist’s day, it was like digging a twenty-yard ditch. We risk humiliation every time we take on the cases you were afraid to treat, and even if you send us straightforward cases too, most endodontists I know will go the extra mile to see your emergency patients post-haste and at just about any time of day they need us. Being a good endodontist, like being a good general dentist, is a lot of hard work.

Know that endodontists have to take care of those who take care of us. If I have to decide whether to
see an emergency from a pipeline referral or a patient from a dentist who only sends six tough cases a year, it’s a no-brainer. If I don’t take the case referred by the pipeline doc, he or she will rightly find someone who will. And that’s fair, they should be able to get that level of service in return for referring even the easier cases.

Also be aware that if you refer all of your endo, you will usually get better service by referring most or all of those cases to one endodontic office, rather than by splitting your referrals. When you become a pipeline referral, you generally get what you want. When you are a low-level referral to several specialists, they will each have better referring offices to which they must cater.

As a final comment about the generalist’s self-interest in referring to specialists; referrals go both ways. When endodontists are asked for the name of a great restorative dentist in town, they are unlikely to send that patient to a G.P.’s office that is known as an “endodontic black hole”, where endo cases only go in and never come out.

It’s OK if you only refer tough cases, but the quid pro quo here is that you have to support your endodontist in charging a fee which will reflect the effort to save those kinds of teeth. The difference between an easy case and an ugly case can easily be four times the effort. A standard molar fee doesn’t even cover the overhead in some of these cases, let alone the heart muscle lost.

When you send a nasty endodontic failure that requires removing a post and the filling material, that has obvious apical laceration possibly requiring surgery after the conventional retreatment, the fee quoted to the patient may be two or three times the standard fee. You should know that if the patient calls our office thirty minutes after the consultation appointment is over and angrily complains about that fee, we will know that the patient left our office, called you and complained, “Dr. Rosenberg said it’s going to cost $1500 to treat my tooth!”, and you sold us out. When you say “You’re kidding!”, or “Oh my God!” it’s over.

The patient will never respect the fee quote, and as I said, your endodontist will know exactly what happened.

Your responsibility, if you choose an endodontist to treat one of your patient’s teeth, is to back the specialist. All it takes is a kind, but firm reply to your patient’s complaint; “Mrs. Jones, I know it’s a lot of money for you but it’s a very difficult case. Remember, it’s a very important tooth for you, it would cost more than Dr. Rosenberg’s fee to replace it with a bridge or an implant, and I sent you there because he is the only one who can save your tooth.”

It’s also OK to send a failure you have been involved in. For those G.P.’s who have had a root canal procedure go bad, there is no one who can support you better than an endodontist. We can tell the patient things that would sound self-serving coming from you or your staff. For instance, when I see a patient with a broken file in their root canal, the first thing I tell the patient is that it happens to all of us (although it should be rare).

Culture a relationship with an endodontist you respect, even if you do most of your own RCT. My parents taught me that you need to establish a “halo effect” before you really need it, because once you need it, it’s too late. A good way to accomplish this is to invite your favorite endodontist to lunch, and ask them about their area of expertise. Buying lunch is not a bad strategy here either.

The best advice I ever heard about what to do when things go awry, was from one of my professors at dental school, Dr. Ron Borer. He said that when all hell breaks loose, you had better stay calm and make certain that every decision that you make from that point is exceptional. Call your endodontist, fully inform them of the problem and circumstances, and tell them to send you the bill. If you take responsibility and the tooth is saved, you will keep the respect of your patient and the endodontist as well.

Perhaps the worst situations in this regard are when a G.P. has an untoward outcome and fails to refer. If the fix works, you can get out of a scrape, but if the
fix doesn’t work, or if the case cannot be fixed after the repair is botched, it is now big trouble.

**Specialists:**

Know that generalists are looking for a condescending attitude on your part. If you can just avoid this one thing, GP’s will think you are a regular guy or gal. If you are arrogant and the locals are desperate for talent they will still refer patients, but as soon as an equally skilled but respectful endodontist comes to town you will be the number two choice. And GP’s are usually the ones who tell newly-graduated endodontists where there are practice opportunities.

Your referring dentists should be able to send patients for diagnostic services and occasionally have some of them returned to you with a diagnosis of non-endodontic etiology for the patient’s pain, such as TMD or a cracked tooth syndrome that will be resolved with an extracoronal restoration. My favorite consult appointment is when I can say that no RCT is needed (and be right). I feel like I have gained the trust of my referring dentist to do the right thing regardless of my own self-interest.

Don’t say that pulp caps don’t work and shouldn’t be done—you sound like an idiot to prosthodontists who do successful pulp caps all the time. If the pulp had no irreversible symptoms and the pulp cap is done to current levels of excellence, it will work nine times out of 10. There are enough pulps dying out there without killing some of them that could survive with the right treatment. You can always do the RCT. The stressed pulp concept of diagnosis makes me uncomfortable because I’ve seen so many examples of its self-serving outcome corroding good clinical judgement by encouraging overdiagnosis.

Be kind in dealing with other dentist’s failures. Instead of resenting a dentist who sends you a botched case, understand that this dentist is one case closer to referring more often. If you disrespect them in their hour of humiliation, they will refer more of their endo cases afterwards, but to someone else. If you back them up when they are in desperate straights, the resulting goodwill is enormous. Even if they never send another case, they will sing your praises to their buddy who may be looking to send their endo out. Also remember, if you have been in town for more than ten years your general dentists colleagues have seen or heard of some your failures as well.

On another note, stop over-enlarging the coronal halves of root canals. It’s not sexy anymore and the technology now exists to definitively treat root canal systems without cranking open the coronal parts of root canals to dangerous diameters. In defense of this criticism I have heard endodontists say, “The root is mine!” But the root is not yours it is your patient’s, and they may need it for another fifty years after your procedure.

Even if you avoid strip perforation after cutting big shapes in small roots, you have still needlessly weakened the root. After two decades of practice, I find that most of my long-term failures (not that many) are due to a loss of coronal seal or root fracture. Carl Reider, the reknown prosthodontist from Newport Beach, CA, once told me that his favorite wish of endodontists was that they figure out some way to just “suck the pulp out of root canals and seal them without weakening the roots.”

Finally, know that your referring dentists sell you to their patients. Return the favor by setting a restorative appointment for the patient in your office before they leave. Find anything good about your referring dentist that you can talk up. If there is nothing good, describe them as being “A piece of work”, or “Quite a guy (or gal)”. If you can’t say that, try not to work with them.

**Altruism as a Survival Strategy**

I’m often asked by GP’s if endodontists are tweaked that I’m sharing knowledge and I answer no. My endodontic colleagues have been very supportive of my teaching efforts. Herb Schilder was right about the greatest threat to endodontics being the “trivialization” of the specialty. Limiting the access general dentists have to endodontic information allows them to think of RCT in overly simplistic terms. If specialists tell them all the detail involved in our consults and procedures they will be aware of the
higher yardstick to which they are being held accountable and they will either train up to attain that level or refer. Even when generalists buck up to doing a better case, they will get tired of the taxing work and refer out at an increasing rate as they achieve greater success in their restorative practices. Remember, endodontists haven’t figured out how to charge for pontics yet.

So if you meet your endodontist for lunch and he or she seems kind of frazzled, you’ll ask and find out it’s because their morning consisted of two one-shot molars, two consults, two emergencies, and four phone calls with referring dentists before noon. When you ask further, you will find out that one of the molar RCT’s they did was a retreat with a post to hang out, and that one of the emergency cases required an extra twenty minutes to explain why the referring dentist failed to refer for the first three weeks of the patient’s pain when the 10 minute emergency appointment at the specialist’s immediately resolved the patient’s symptoms.

When you consider this relationship from a standpoint of abundance, you’ll be glad that there are endodontists nearby to take on cases with these risk profiles, who will be on call for you and who will see your patients in pain when you want them out of your schedule. Then, when you see that faraway look in their eyes that came from a tough first half of the day, perhaps you’ll feel good about buying them lunch. Remember, generosity begets abundance.